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DEPT FOR S/OFFICE OF GLOBAL AIDS COORDINATOR
STATE PLEASE PASS TO USAID FOR GLOBAL BUREAU KHILL
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Summary

¶1. Summary. Every two weeks, USEmbassy Pretoria publishes a public health newsletter highlighting South African health issues based on press reports and studies of South African researchers. Comments and analysis do not necessarily reflect the opinion of the U.S. Government. Topics of this week's newsletter cover: Rural Communities to Shape Own HIV/AIDS Programs; Asthma Rates Rise Among SA's Teens; Government Needs to Treat HIV-Positive People Sooner; Treatment of Children a Lower Priority ARV Treatment; Breastfeeding Reduces HIV Transmission; Health Department Proposes Reforms to Funding Public Health; South African Women More Likely to Know HIV Status; and Global Fund Grants 3 Months Behind Schedule. End Summary.

Rural Communities to Shape Own HIV/AIDS Programs

¶2. A new project by South African NGO, the Center for HIV/AIDS Networking (HIVAN), will enable rural communities across the country to develop their own programs to deal with the impact of HIV/AIDS. Since July 2003, the HIVAN team has been investigating how people in rural areas respond to HIV/AIDS despite inadequate resources, including a lack of basic infrastructure and access to health facilities, while suffering from high rates of unemployment and illiteracy. The survey found that the involvement of local stakeholders was crucial in implementing prevention campaigns. After preliminary research, HIVAN recently launched its pilot project, which will run over a three-year period in a deeply rural, poverty-stricken and isolated area in the Mtunzini district of northern KwaZulu-Natal. Based on the information obtained from the pilot, a model of best practices will be created and implemented in other rural areas throughout the country. HIVAN's program is based on extensive consultation with communal stakeholders, giving it support in the community. The nearest health care facility to the project is the Empangeni Hospital, and few residents can afford the transport to get there.
As a result, they have to rely on the services of a mobile clinic that visits the area once a month. But when it rains, the potholed and sandy roads become inaccessible, and the sick have to wait even longer for assistance. HIV testing is not offered by the mobile clinic either, so information on HIV prevalence figures in the community is sketchy, but an HIVAN survey conducted among 100 residents in the project locale, estimated that 35 percent of pregnant women and 16 percent of adults were HIV-positive. Families and caregivers nursing terminally ill AIDS patients were isolated and received very little community support. When HIVAN first started interacting with the community, it found that the only mobilized groups dealing with HIV/AIDS were the under-resourced community health and home-based workers, with none receiving HIV/AIDS-related training. Subsequently, a committee consisting of faith-based organizations, traditional healers, community health workers, tribal authorities and local health officials was established. The communal committee will meet on a regular basis and, with the help of HIVAN, develop an HIV/AIDS program that corresponds to the specific needs of the area. The NGO will also facilitate HIV/AIDS information sessions, and promote critical thinking about social roots and stigma. Since the beginning of this year, HIVAN has provided 75 community health workers with HIV/AIDS-related education and 10 HIV/AIDS focus groups have been established in the area. Over the next three years HIVAN will continue training community health workers and launch two AIDS peer-education programs - one targeting the youth, the other geared to the men in the village. Source: All-africa.com May 4.

Asthma Rates Rise Among SA's Teens

¶3. Researchers at the Red Cross Children's Hospital have warned that asthma rates are rising among South African teenagers, and may dramatically increase among Xhosa-speakers as their families adopt western lifestyles. The findings from

two separate studies also highlight concerns about misdiagnosis and inappropriate treatment of asthma. Symptoms of asthma, allergic rhinitis and eczema had increased markedly in Cape teenagers over the past seven years. They repeated a survey conducted for the 1995 International Study of Asthma and Allergies in Childhood among more than 6000 13-to-14-year-olds from 53 Cape Town schools in 2002, and found the proportion of children reporting severe wheezing had risen from 5.2 percent to 7.6 percent. Exercise-induced wheezing was reported by 32 percent of the teenagers compared with 21.5 percent in the earlier study. Scientists suspect that the worldwide rise in allergies is linked to the way people live, suggesting that bacteria-free homes and sterilized food make people more susceptible to hay fever, asthma and eczema. A series of studies has found that children are less likely to get allergies if they are raised on farms, live in rural areas, or are exposed to plenty of infections when they are young. Western diets and a lack of exercise are also linked to the rise in allergies. The 2002 study also found a drop in the proportion of children who had had their asthma diagnosed by a doctor. SA has the fifth-highest asthma fatality rate in the world, although it ranks only 25th for asthma prevalence, according to the Global Initiative for Asthma. A separate study found African teenagers appeared to be more genetically disposed to allergies than whites, suggesting the incidence of asthma and other allergies would rise "exponentially" among Xhosa speakers as they adopted western lifestyles. Source: Business Day, May 3.

Government Needs to Treat HIV-Positive People Sooner

¶4. Treating HIV positive people when their CD4 counts are above 200 is not only lifesaving, but also more cost effective, according to research conducted by Robin Wood of the University of Cape Town's Desmond Tutu HIV Research Center. At present, people with a CD4 count (measure of immunity in the blood) of 200 or less are eligible for ARV drugs at government clinics. Placing patients on ARV treatment when their CD4 cell counts are between 200 and 350 not only improved mortality, but was also cost effective. According to calculations by Wood, life expectancy for an HIV positive person in the absence of antiretrovirals is around 6.3 years. This goes up to an average of 17 years if a person with a CD4 count of less than 200 starts ARV treatment. Starting ARV treatment with the patient having a CD4 count of between 200 and 350 increases life expectancy by a further six years, extending life expectancy to 23 years. Nine clinics forming part of the HIV Center's anti-retroviral program in Cape Town recorded a death rate of only 7.8 percent after 12 months of therapy. The death rate was measured within the first 12 months of placing the patients on anti-retroviral therapy. However, when Wood measured the death rates from the time of referral (from the clinic to the ARV site) the picture changed dramatically. It was found that 28 percent of patients died from the time of referral until the time they are placed on treatment. Many patients had died of wasting syndrome, a condition for which there is no specific treatment, while others died of tuberculosis, Kaposi's sarcoma and cryptococcosis. The critical need is to find and treat patients early, and Wood said the tuberculosis program was a good place to start as 60 percent of patients entering the ARV program had had TB in the past. Source: Health e-News, April 28.

Treatment of Children a Lower Priority ARV Treatment

¶5. According to Dr Haroon Saloojee of Wits University's Community Pediatrics Division speaking at the first "Priorities in AIDS Care and Treatment (PACT)" conference, at best 3,000 children are on antiretroviral (ARV) drugs countrywide, whereas between 30,000 and 45,000 of the country's 230,000 HIV-positive children needed the drugs. Statistics showed child mortality had steadily increased since 1996, with AIDS-related diseases accounting for 40 percent of deaths of children under the age of five. A further 10 percent died of diarrhea while around 11 percent of deaths were due to low birth weight, both of which could be HIV-related. Gauteng placed 1,319 children on ARVs, 12 percent of those accessing the drugs in the province. In Mpumalanga only 31 children, 1 percent of those on ARVs, were on the drugs and in KwaZulu-Natal, at best, 500 of its 9,000 patients were children. Dr Saloojee identified the following obstacles facing widespread treatment of HIV-positive children: (1) staffing shortage with up to one third of posts in the public health sector vacant; (2) pediatric guidelines on treatment have to be finalized; (3) too few sites accredited for pediatric anti-retroviral treatment: (4) reluctance by the clinics and hospitals to start treating children unless there is a pediatrician on the staff; (4) Parents being treated at different sites from their children; (5) failure and reluctance to test children; (6) A lack of pediatric drug formulas and their high prices; (7) complex dosages, foul tasting syrup, refrigeration requirements and quick expiry dates; (8) reliance on herbal medicine; and (9) sharing medicine with family. Saloojee called for the fast tracking of accredited sites, the urgent distribution of treatment guidelines, the incorporation

of testing into primary healthcare services and the overall strengthening of the prevention of mother to children transmission program (where many children would be identified in the first place). Source: Health e-News, April 28.

Breastfeeding Reduces HIV-Transmission

¶6. Exclusive breastfeeding substantially reduces the transmission of HIV from mother to baby as well as infant death, compared with partial breastfeeding, a study in Zimbabwe has confirmed. Breastfeeding causes nearly 40 percent of all pediatric HIV infections, yet also prevents millions of child deaths every year by protecting infants from diarrhea and other infections. A study conducted by the Johns Hopkins Bloomberg School of Public Health, the University of Zimbabwe and Harare City Health Department found that exclusive breastfeeding substantially reduces the transmission of HIV from mother to infant as well as infant mortality, compared with partial breastfeeding. Infants who were introduced to solid foods or animal milk within the first three months were at four times greater risk of contracting HIV through breastfeeding compared to those who were exclusively breastfed. International guidelines currently recommend that HIV-infected mothers should avoid all breastfeeding, but only if replacement feeding is acceptable, feasible, affordable, sustainable and safe. For the large majority of African women, this isn't the case and breastfeeding is the only choice. The study was conducted among 14,000 pairs of mothers and newborns who were part of the ZVITAMBO project, which examined the effects of vitamin A supplementation in Zimbabwe. From this group, the researchers followed 2,060 infants from birth to age 2 who were born to HIV-positive mothers. Information about infant feeding was collected at ages six weeks, three months and six months. All infants were breast fed, but were categorized as exclusive (breast milk only), predominant (breast milk and non-milk liquids) or mixed (breast milk and animal milk or solids) breastfeeding. In their analysis, the researchers found that mixed breast feeding quadrupled mother-to-infant HIV transmission and was associated with a three times greater risk of transmission and death by age 6 months when compared to exclusive breast feeding. Predominant breastfeeding was associated with a 2.6-fold increase in HIV transmission as compared to exclusive breastfeeding. The study is published in the latest issue of the AIDS journal. Source: Health e-news, April 28.

Health Department Proposes Reforms to Funding Public Health

¶7. Trying to address the inequities in health care spending, the Council for Medical Aid Schemes (CMS) has proposed to introduce a social health insurance system by 2010 where all in formal employment would have to buy medical insurance, which would double the number with insurance to about 14 million and reduce those relying on public health care facilities from 85 percent to 65 percent. The proposed health reforms have four phases. Phase 1 (2003-2007) would limit private sector health care cost increases and improve the quality of public hospitals. Phase 2 (2004-2008) would introduce a risk equalization fund and risk adjustment subsidy to medical insurance companies as well as sponsoring a state-sponsored medical insurance program requiring civil service participation. Phase 3 (2005-2008) would require medical insurance for middle-to-high income workers and would encourage voluntary insurance for low-income workers. Phase 4 (2008-2009) would require workers to contribute through a 5 percent payroll tax to a National Health Insurance fund, with higher income earners able to contribute more in order to receive more comprehensive health care coverage. By 2010, the poor would receive free basic public health care coverage. CMS, reporting to the Department of Health, acknowledged resistance from trade unions and other governmental departments (mainly Treasury), and suggested that membership of the state medical insurance program might be mandatory for new employees only. The Department of Treasury favors a limit on the amount of medical aid contributions that are tax deductible rather than imposing a new 5 percent payroll tax and wants the Department of Health to improve its financial management and collection services before imposing additional taxes. Public hospitals currently charge an income-based fee, now generating less than R300 million ($50 million, using 6 rands per dollar) from R500 million in 1996. In March, the Health Department announced fee increases in public hospitals. For example, patients earning less than R3,000 per month ($500) will have to pay R55 for a consultation, compared to R20 previously. The Department of Health also mandated prescribed minimum benefits (PMBs), a list of diseases and conditions for which all medical insurance policies must insure, and increased the cost of entry for poorer people to private health care. A medical insurance package just covering the PMBs costs approximately R200 per month. Agreement with labor unions and other governmental agencies will be required if the proposed plan becomes operational. Source: Financial Mail, May 6; Mail and Guardian, May 2-6.

South African Women More Likely to Know HIV Status

¶8. A survey, HIV and sexual behavior among young South Africans, found that 10 percent of 15-24-year-olds have HIV but the prevalence rate for women was more than three times that of men. The research, by the University of Witwatersrand's Reproductive Health Research Unit, loveLife and the Medical Research Council, found that 77 percent of patients who tested positive were women. Seventy percent of people getting tested at government voluntary counseling and testing centers are women. The survey reported significant gender differences, finding that 25 percent of females surveyed said that they had been tested while only 15 percent of males did. A recent Nelson Mandela study of HIV/AIDS showed that 13 percent more South African women than men know their status. Source: Cape Times, May 10.

Average Global Fund Grants 3 Months Behind Schedule

¶9. Global Fund grants are, on average, three months behind schedule, according to an analysis conducted by Aidspan, a non-governmental organization (NGO) that monitors Global Fund activities. The study compares each Global fund grant's planned disbursement schedule with the actual disbursement schedule and determines whether the grant is on time or ahead of schedule, up to 3 months behind schedule, between 3-6 months behind schedule, over 6 months behind, or too new for rating. Of the 311 grants, 45 (14 percent of the total) have an Aidspan rating of "A: On or ahead of schedule"; 140 grants (45 percent) are rated "B: Up to 3 months behind schedule"; 61 grants (20 percent) are rated "C: 3 to 6 months behind schedule"; 60 grants (19 percent) are rated "D: Over 6 months behind schedule"; and 5 grants (2 percent) are rated "N: Too new for rating". Grants to Eastern Europe and Central Asia currently have the highest average rating; they are on average 1.2 months behind schedule. Grants to North Africa and the Middle East come next, being on average 2.0 months behind schedule. Grants to each of the four remaining regions of the world are on average between 3 and 4 months behind schedule. There is no statistically significant difference in performance between grants for HIV/AIDS, malaria, or TB. Global Fund grants to PEPFAR (Presidential Emergency Plan for AIDS Relief) countries are on average 3.3 months behind schedule, and grants to non-PEPFAR countries are on average 3.0 months behind schedule, not a statistically significant difference. For Sub-Saharan Africa, the average grant delay was 3.4 months while South Africa's average reached 7.88 months. Source: Global Fund Observer Newsletter, issue 44, May 5.

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